**PLAN OF CARE FOR: ☐ C.H.O.I.C.E.**
**☐ _____ WAIVER ☐ OTHER _____**
**☐ IPAS Only ☐ PASRR / MI or ☐ PASRR / DD**

State Form 45994 (R2 / 7-98) BAIS 0019
Approved by State Board of Accounts, 1994

This state agency is requesting disclosure of your Social Security Number in order to expedite processing of your Plan of Care. Disclosure is voluntary and you will not be penalized for failure to disclose SSN per IC 4-1-8.

| Last name | First name | Middle initial |
|---|---|---|
| | | |

| Medicaid number | Date plan completed |
|---|---|
| | |

| Social Security number | Area agency on aging number |
|---|---|
| – – | |

## PROBLEM STATEMENT

## GOAL / OBJECTIVE

**PLAN OF CARE - EFFECTIVE FROM:** **TO:**

| SERVICE | PROVIDER | FUNDING SOURCE | FREQUENCY | TOTAL UNITS | COST PER UNIT | TOTAL COST | MONTHLY COST | START DATE | END DATE |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

## C.H.O.I.C.E. PROGRAM

☐ I have reviewed the services contained in this plan, and I choose to accept this plan and the services explained to me.

☐ I have reviewed the services contained in this plan, and I choose to accept this plan and the services explained to me. I hereby agree to notify the case manager of any changes in my income or any changes that may affect the plan of care or my monthly C.H.O.I.C.E. cost share percentage of _____ , which equals $ _____ .

| | | |
|---|---|---|
| Signature of Client | | Date |
| Signature of Client Representative | Relation | Date |
| Signature of Case Manager | C.M. Code # | Date |
| Signature of AAA | | Date |
| Signature of Physician *(Medically Frag. Child Waiver Only)* | | Date |
| Signature of IDDARS Service Coordinator *(D.D. Waiver only, BDDS Placement Authority)* | | Date |

| First Quarter | Second Quarter | Third Quarter |
|---|---|---|
| Initials: _____ Date: _____ | Initials: _____ Date: _____ | Initials: _____ Date: _____ |